Towards... Empowerment of Women & Children

CHETNA

CHETNA which means **"awareness"** in several Indian languages is an acronym for Centre for Health Education, Training, and Nutrition Awareness. CHETNA is a non-government support organisation having its head office in Ahmedabad in Gujarat State of India. Its mission is **to assist in the empowerment of disadvantaged women and children to gain control over their own, their families' and communities' health.**

Founded in 1980, CHETNA made its beginning with a project aimed at improving the effectiveness of the government implemented supplementary feeding programmes for mothers and children in Gujarat. Over the past two decades, CHETNA has broadened its activities in the field of health and nutrition education for women and children in rural, tribal and urban areas of Gujarat and Rajasthan through implementation of different project/ programme activities.

At present, CHETNA is supporting Government and Non-Government Organisations (GOs and NGOs) through its two Resource Centres, CHEITAN, the Child Resource Centre (CRC) (initiated in June 1991) and the Women's Health and Development Resource Centre - CHAITANYAA (initiated in October 1992).

Together the centres address the needs of children and women during different stages of their lives. Capacity Building of NGOs and GOs is done through conducting "Training of Trainers" (TOT) on specific concerns of women and children. Presently, CHETNA is active in building the management capacities of education/health practitioners/supervisors, with a view to develop their capacities and skills, to enable them to implement their field based health programmes more effectively from a gender perspective. The training programmes at Ahmedabad are conducted by CHETNA at its Training Centre, which is equipped for residential programmes as well. In Rajasthan, CHETNA has created a cell to facilitate its outreach in the state.

CHETNA has also initiated at is premises the Lilavati Lalbhai Holistic Health Centre which caters to the curative and preventive health care needs of children and women residing in nearby slum areas. Efforts are also made to develop linkages with other educational and developmental organisations like Shramik Vidyapith, Self Employed Women's Association, Ahmedabad Municipal Corporation and Civil Hospital for imparting vocational training, providing referral services and facilitating formal education to enable the overall development of women and children.

CHETNA develops need based training and education materials for wider dissemination. Its Documentation Centre addresses the information needs of individuals, GOs, NGOs, activists, academicians and researchers working in the areas of health, education and development of children and women.

CRC

CHEITAN

CHILD RESOURCE CENTRE

About 40% of our human resource consists of children. It is therefore very important to nurture this large vulnerable group to ensure that they develop to their optimum potential.

The nutrition, health and developmental needs of children must be urgently met to prevent undesirable effects on their growth and development. The grim reality that thousands of children die or fall ill and develop disability in our country highlights the urgent need to review existing policies and programmes. Formal schools fail to provide meaningful and life useful health, education and skills limiting children's participation in health promotion. Majority of adolescents depend on unauthentic sources of information as the information and services are either not available, or they are irrelevant or inaccessible.

In existing development programmes today, children are viewed as passive recipients and beneficiaries. There is hardly any scope for their participation and action. This situation promotes the dependence of children on adults, thereby reducing their ability to take responsible decisions later in life. Several questions arise, as we view the reality and scenario of Indian children.

Can a child be sure of her/his healthy survival today?

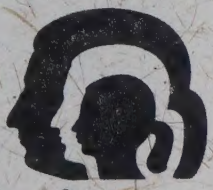
Can a child question the kind of knowledge/information and the way it is imparted in schools and by the media?

Can a disadvantaged child, who does not attend school, have equitable access to health and nutrition information/services?

Can an adolescent hope to receive factual information and quality service on sex related matters from authentic sources?

India, as a signatory to the U.N. Convention on the Rights of the Child has committed itself to actualise children's participation and hence needs to create an enabling atmosphere where children can become active partners in their own health and development concerns.

With this concern in view, CHETNA initiated the Child Resource Centre (CRC) with a vision of a society where empowered, healthy and happy children can become active partners for their own, their family's and community's health.



Chaitanyaa

The World Health Organisation (WHO) defines health as "a state of complete physical, mental and social well being and not merely the absence of diseases". According to this definition, do Indian women enjoy good health? Does society recognise women's contribution in an equitable and non-discriminatory manner? Can a female child expect the same from life as a male child?

A close look at the state of women's health and health care in India reveals that women lack adequate health services and suffer from discrimination throughout their lives. As a result, women have little sense of their own self worth.

Not surprisingly the existing health care programmes reinforce this grim situation: women receive health care solely because of their child bearing role. Women as non-child bearing individuals, i.e, infants, children, adolescents, single and post-menopausal women are largely neglected.

Increasingly, women's groups are recognising that a woman's health cannot be separated from the society in which she lives. .lm5

With this conviction, CHETNA has initiated CHAITANYAA - Women's Health and Development Resource Centre which envisages an egalitarian and just society where empowered women live healthy lives.

CHILD RESOURCE CENTRE	CHAITANYAA

Vision

CRC envisages empowered, healthy and happy children who can contribute to the development of the Nation	CHAITANYAA envisages an egalitarian and just society where empowered women live healthy lives.

Mission/Goal

To empower children to become active partners for their own health and that of their family and community by equipping adults working with them	To enhance women's health status by empowering them to gain control over their own health and development concerns.

Strategy

To support GOs, NGOs and other autonomous agencies that work in the states of Gujarat, Rajasthan and Madhya Pradesh (M.P.), India, by strengthening their capacities to implement and manage effective health and development programmes for children and women.

Activities

'Activities focus on awareness raising and sensitising, capacity building of organisations, documenting experiences, developing/disseminating education/training materials, networking and advocating on issues concerning children and women.

CHEITAN

CHILDREN AS PARTNERS FOR HEALTH

Children and the present health scenario

From Needs to Rights

During the past four to five decades, the world's approach to children has changed considerably. The idea that children have special needs has given way to the conviction that children have rights, the same spectrum of rights as adults. This conviction has been expressed through the Convention on the Rights of the Child by the United Nations in 1989. The Convention has so far been ratified by 189 countries including India, which signifies that these countries have committed themselves to provide four broad sets of rights to children namely, **Right to survival, protection, development and participation.** A significant implication of this change in focus is that now children's active partnership in programmes is imperative for the effectiveness of any programme.

Field Realities

The existing national level programmes that address the developmental concerns of children, such as Early Childhood Care and Development and School Health , if reviewed in the above context, falls considerably short of expectations:

a) Although they continue to address the issues of survival, protection and development, this is done more from a **needs** rather than from a **rights** perspective. The right to participation, the most fundamental of all human rights that gives a larger meaning to all the other rights, has not yet been addressed in practice. Many child-centered education and development programmes merely consider the future value of investing in children and do not accord due importance to securing their rights. In addition, these programmes are service oriented and expensive. Hardly any programme or policy reflects the potential

of children as active partners for health. These programmes also do not acknowledge children's potential and ability to influence the health practices of their family and communities.

b) In addition, infrastructural shortcomings of health education and development programmes make them ineffective and inefficient. Several reasons are at the root of this reality

* In order to develop effective programmes from innovative ideas, organisations require resources including time, money and human power coupled with the potential and capacity for enabling human resource development. In the absence of these inputs, the creative process leading to effective health education has a limited impact.

* Lack of documentation means that innovative approaches and lessons learnt from experiences are not made available to a wider audience and thus have limited possibilities for replicability.

* Many field based organisations are extremely preoccupied in implementing existing programmes that they fail to take advantage of opportunities for scaling up programmes and delivering services to a larger population.

* Many a times, programmes are unreplicable because they are too locale specific or highly expensive.

* In some instances, even if innovative efforts are made, they often go unnoticed by policy makers and others who count.

c) A closer look at the situation of children in their families reveals that older children, in the majority of cases girls, often act as surrogate parents taking care of younger children when both parents are away at work. This situation tends to damage the healthy development of both the older and the younger child. First, the older child, burdened with responsibilities is unable to take part in learning opportunities or experience the joy of childhood. Secondly, because the older sibling does not have the basic child health and development skills required to take proper care of the younger child, the health and development of the younger child is compromised.

Keeping the above scenario in view, two strategies that could ensure that the desired focus on the rights of children becoming a reality in developmental programmes are:

* providing learning opportunities especially life useful education and skills to children through formal and nonformal channels. In life useful education, the significance of providing health education assumes a specially significant role in the aforementioned context.

* sensitising adults, in all their multifarious roles vis a vis children, towards children's potential and capabilities to be active partners in their own development and in that of their family and community.

Relevance of Health Education for Children

It is important that the health education process start as early as possible and includes children because children are critical stakeholders in their own health. Catching them early to prevent harmful habits makes better sense than trying to change habits later in life after they have been internalised. Children can be effective change makers in their community because they have the time, opportunities and the required communication skills. The information they gather on health is disseminated amongst their juniors, peers, elders and within their community. Today's children possess the potential to influence three generations: their parents, their peers and later in life their own children.

Sensitising Adults and Capacity Building of Organisations

In order to translate this into reality, an important and major intervention required entails assisting adult practitioners managing these programmes, to realise the need to focus on children as a valuable resource so that they are willing to work towards making children's rights, especially their right to participation a reality. As children's needs are increasingly approached from a rights perspective, service provision is replaced and complemented by advocacy for children's rights. This perspective assigns responsibility for children's development to society and government. It is imperative then, that the perspective of key development

practitioners be built and organisations strengthened, to enable and equip them to implement and manage programmes wherein children become active participants. This is possible through gender sensitive, participatory, need based training for various levels of functionaries working with children.

CHETNA aims to make its contribution to the empowerment of children, especially disadvantaged children through:

***advocating** the need to recognise children as partners;

***developing** training modules to help strengthen individuals, practitioners, organisations and networks to enable them to promote children's participation in their programmes.

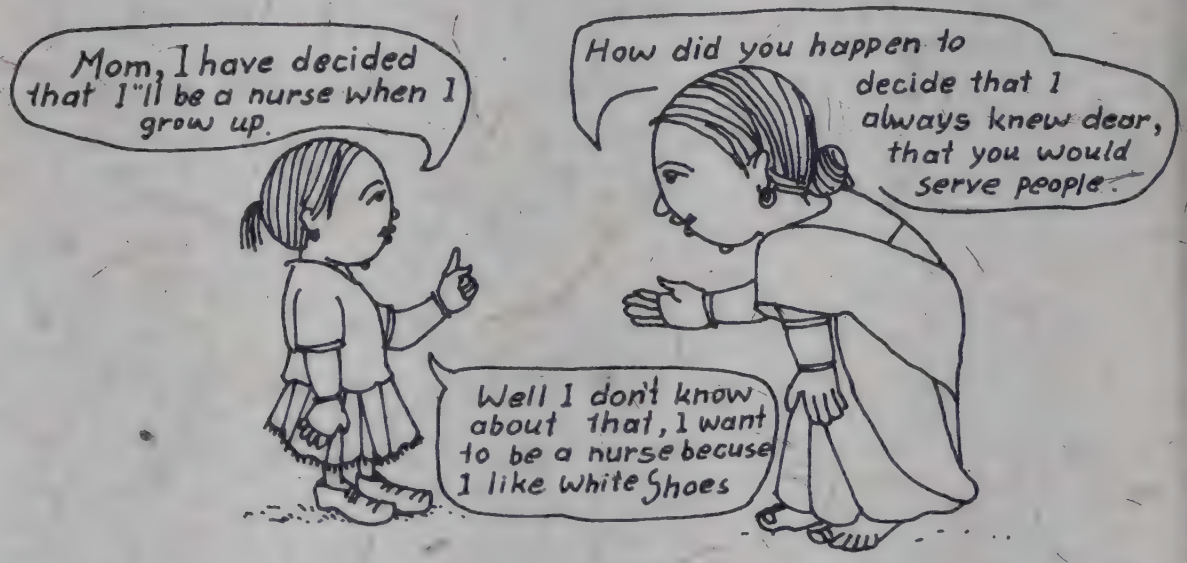
To address this need, CHETNA has pioneered an approach - **Children In-Charge for Change (CIC for C)**. Children In-Charge for Change is the proposed strategy to meaningfully link the right to participation of children to a more sensitive child-focused development. The strategy envisions equipping and enabling children to participate fully and responsibly not only in activities but also in decision making in the development processes particularly in those that affect their own development. A shift in the perspective and mindset of adults working with children can ensure that children get their legitimate right to participate so that they develop into happy, capable and responsible adults.

It is not only enough to canvass children's participation in health but it is also necessary to suggest ways of doing so. One of the major concerns is that often in a teaching and learning situation the didactic methods used results in a wide gap between the reality and the learning that takes place.

Children are capable of being equal partners in their development if they are provided appropriate opportunities,support and disciplined guidance. The extent of their development and learning depends on the extent to which we are able to create an environment for learning and empowerment.

Children grow, learn and develop at their own pace, in their own ways. It can be said that children of all ages learn best in an enabling,

secure, supportive and challenging environment. Children In-Charge for Change advocates a **Child-Focussed** environment which has been recognised as the most appropriate environment for facilitating optimal learning among children.



Creating a Child Focussed Environment

Child focus is basically a point of view, an ideology of the development community working with children. A child focussed approach of teaching-learning views the child as an autonomous individual. Its aim is to make a positive difference in the child's life. It believes that children are 'social players' in their own right who make their own social, economic and cultural contributions to society.

The **role of an adult** is very crucial in the process of child focussed learning. It is that of a **facilitator**,i.e. someone who assists the child to develop her/his potential. Child focus implies that a facilitator should be well aware of several concerns.

These include the child's character, background, abilities and interests. The children's developmental level, pace of learning as well as their social skills must be taken into account while developing modules. Connections between the child and the school and other

organisations/institutions must also be duly acknowledged.

In India, more than half the population of school age children, aged 6-14, are not in schools. The health and the education systems fail to respond to the needs of these children. Even if the children are enrolled into schools, the teaching learning methods commonly used often alienate the child from her/his reality rather than establish a connection between the two.

The basic philosophy of the child focused approach is that every child has the right to learn, enjoy and play at her/ his own pace. Understanding children's potential, an assumption is made that they can act as change agents in the community by taking the health education messages to the family and the community.

The rigidity of the system, ignorance of the educators in terms of lack of sensitivity, motivation and creativity in learning methods and irrelevance of the present education system, leads to underutilisation of education and children into undesirable lifestyles.

Enhancing Child Focussed Health Education

Considering the importance of health one can realise the need to make health education practical, interesting and leading to action. Thus various flexible and creative child focussed approaches to health education are recommended. The critical factor is not to forget what it is to be like a child.

Activity oriented teaching provides an alternative and innovative method of learning which addresses the impracticalities of the traditional education system. It gives children choices in learning and allows them to learn at an appropriate pace. This type of learning also enhances the problem solving, communication abilities and confidence among children. It leads to initiating action and sets out to make a difference in the children's own health and their overall development and to include people around them. Health education imparted through active participation ensures that information reaches the whole community.

The transmission/communication of information by children to the community builds up reciprocal and mutual links between children,

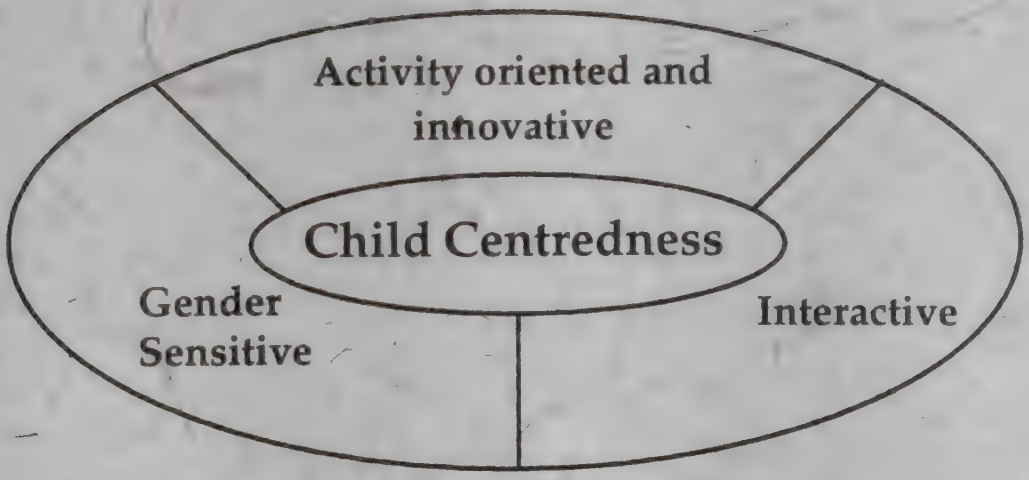
adults and the family, which is conducive to child development.

We must demonstrate to the community the role that children can play in improving the health of families. A secondary gain of child focussed health education is that it relies on children's capabilities and must therefore build their confidence. This leads to improvement in their quality of life.

Teacher Training colleges should include health education as one of the important life relevant subjects to be taught and emphasis needs to be laid on the methodology of teaching. The activity oriented child focussed learning will not only be effective for children but would also make work more rewarding for the teacher and increase her/his motivation to work.

Finally the policy makers and planners need to develop sensitivity towards the needs and potential of children. There is a lacunae at the school age level in terms of health education programmes which need to be addressed. The emphasis should be on preventive and promotional health rather than responding to the curative and disease oriented response to health. The health personnel also need to follow this approach to health to increase the effectiveness of their work.

Measuring impact on children has to be a fundamental part of any child focussed development programme and will indicate whether the programme is making a measurable difference in children's lives. Child specific indicators can be developed for any type of development activity, from community level work to macro level advocacy.



The basic philosophy of CRC is to promote and enhance child centred health education. CRC believes in three basic principles essential for successful child centred health education.

Child centred health education should be:

(1) Activity oriented and innovative

Teaching and learning must be activity based and innovative. These pre-requisites ensure that education becomes interesting and that it is more effective in the long term.

(2) Gender sensitive

Because the girl child is continuously being discriminated against it affects her health, self esteem and social status, as well as the society at large. CRC believes that it is important to sensitise young minds and their parents/society towards gender discrimination so as to bring about positive changes in the lives particularly of girls, and the overall society.

(3) Interactive

CRC believes that health education must consider the existing social and cultural environment of children. For one, children constantly interact with family, peers and the community. Secondly, as health cannot be viewed in isolation, child centred health education must acknowledge the influences of other sectors including government, non-government and other local bodies.

Child centred health education must also acknowledge the limitations and potential of children. Thus, child centred health education must take into account all the interacting factors.

EARLY CHILDHOOD CARE AND DEVELOPMENT (ECCD)

0-6 years

Early Childhood Care and Development refers to the period of 0-6 years which is considered as the foundation years as it addresses the needs of the children under three years of age and the concerns of children in the pre-school years (3-6 years). An integrated approach to development in these years is an essential cornerstone keeping the aim of holistic development in view.

Just as this is a period of accelerated growth and development in a child, it is also one of increased vulnerability to infections which are vaccine preventable. The incidence of malnutrition is also the highest in this age group increasing the severity of the problems that adversely affect the status of their health, nutrition and development.

During the pre-school years, the tremendous pressure on children to learn the 3 r's namely reading, writing and arithmetic and at the same time lack of adequate stimulation to explore, experiment, experience and be excited completely demotivates the child to

pursue further education. It also results in lower academic achievements and possibly lower status in society. This is aggravated by pressures of performing well within the formal education system, competing to achieve to sustain within the modern competitive world leading to overall stunted development.

The break up of the joint family system and lack of involvement of the community, particularly men in child care also acts as a severe constraint. Many parents are often either ignorant of the development needs of their children or are not able to devote adequate time and attention for quality care due to economic realities. The responsibility then, of child care, in the absence of parents falls on the shoulders of the older siblings, especially young girls who as a result are unable to attend school. Alternately, the support of institutionalised care is sought.

Gender discrimination affects the girl child most severely in this age group. Lack of adequate nutrition leads to malnutrition in the adolescent years. These young women give birth to weak and underweight children in later years and this cycle continues throughout life. The situation is further aggravated due to lack of proper education. Adequate health care, support and nutrition services provided to the girl child during the early years of her life can enable and empower her in numerous ways:

she can participate better in educational , economic and social activities that will help her grow as a healthy, happy and responsible adult;

she can actively participate in decisions and activities that contribute to the health of the other family members and/or the community because by investing in her, an important message that will be conveyed to her is that she matters and that she is an individual worthy of attention and respect.

While various programmes are being implemented at the Government and Non Government level, the programmes are

unable to reach the children who most need it. Available programmes are unable to provide quality care due to inadequate resources, both financial and human. The priority accorded to issues in the existing policies is often misplaced, thereby increasing the gravity of the problem.

It is therefore important to realise at all levels that a child is an individual who is capable of participating in his/her own development. To make this a reality it is important that policies and programmes focus and encourage home based, centre based and community based child care with focus on under three. In such attempts, it is extremely important to bear in mind that women who have traditionally been the sole child care providers also have an inherent need and right for self realisation and economic independence. Therefore, facilities for creches and childcare services should be provided at work places and near schools so that the young girls can participate in the educational and economic developmental activities with ease.

Thus, in advocating appropriate and adequate early childhood care, the role of men and the sensitisation of communities that it might entail should also be emphasised. Policies and programmes should encourage positive traditional practices of child rearing, adopt innovative participatory training approaches and implementation of the programmes, sensitise adults directly affecting a child's life, use easily available technology, integrate ECCD as an important component of all the programmes, eliminate gender differences and utilise motivational strategies for implementors. Above all, allocation of appropriate funds for ECCD programmes is a crucial requirement. These important steps can provide a more joyful and meaningful life to our children.

CHETNA envisages to continue the capacity building efforts and development and dissemination of IEC material. It plans to play proactive role in networking and advocacy for improving the quality of child care services in the perspective of these services as a support to women and adolescent girls. Action research projects will also be taken up to develop relevant intervention strategies.

INTERVENTION FOR SCHOOL AGE CHILDREN

6-14 years

Children in the age group of 6-14 years have so far remained neglected by the majority of the developmental programmes. Fortunately, with the resolution of the Indian government to reach the goal of **Education for all by the year 2000**, the focus of the developmental programmes has begun to shift to **School Age Children.**

Children are influenced through many sources, the most important being their home, school and communities. The fact that, during this early phase of life when the pace of physical and intellectual development is rather rapid, positive influences created can have far-reaching benefits in adult life and accords special significance to the need of imparting health education during childhood. Children can become alert, health conscious and remain fit and well if they are equipped with health related information and skills. A healthy child will not remain absent from school due to repeated illness and will perform better at studies. Being part of and having more time with the family, children are also able to spread health messages and practices to it as well as to the community. Children in this age group can thus be viewed as both recipients and transmitters of health messages.

Concerted/sustained educational intervention is capable of changing/influencing health behaviour considering the inadequate outreach of the present health system, the widespread poverty and the vastness of problems of ill-health and undernutrition in India. Health education through formal communication channels can enable individuals to resort to preventive care/adopt a broader concept and practices of health.

As many as 86.7 million in this age group are enrolled in primary schools in India and thus the formal system provides an easily available opportunity for influencing health related attitudes and behaviour. Furthermore, daily and sustained contact with children affords the teachers with an opportunity to monitor children's health. In rural India, majority of the children are the first generation learners and they are respected for their opinions. The rural school system provides a comprehensive infrastructure that can meaningfully synthesise and integrate currently compartmentalised and fragmented health programmes designed to address the needs of the rural communities.

Adequately developed school health services will help to identify health problems so that they may be dealt with. Moreover ideas and skills learnt at school will prepare a child for health decisions in later life. Thus schools provide an unmatched opportunity for influencing the knowledge, beliefs, attitudes and practices of children and of the people of the community through them.

The aspects of the educational system that are likely to facilitate such efforts are :

*teachers employed in primary schools are adequately and appropriately trained

*some amount of health, hygiene and nutrition teaching has always been a part of the school curriculum

*in recent years, alternative approaches have been experimented upon by government agencies and non government organisations with the purpose of incorporating them in regular education and health systems as well as in the non formal sector.

However this reality also poses many challenges in the optimal

utilisation of the existing opportunities, due to a variety of reasons that include,

* lack of health and nutrition awareness among children, teachers parents and community.
* relatively low priority accorded to health and nutritional aspects at the policy and programme level and even in the formal school system.
* gender discrimination is at its highest level in this group because of socio-economic reasons which deprive the girl child of not only education but also other advantages and exposure offered by the formal school system
* children, or for that matter even adults, do not consider health as a high priority asset and do not recognise the role they can play in affecting it.

Although the long term goal to address these challenges would require introducing systemic changes, intermediary steps/ interventions need to be made to remedy certain aspects of the situation. Our experience is that sustained short term interventions at school level and frequent orientation meetings with school authorities and teachers can help maintain the enthusiasm, originality and creativity of the teachers in incorporating and integrating health aspects into education activities. Over a period of time due to such interventions the teachers and policy makers can be gradually influenced to accept the changes. Besides, inclusion of parents in such interventions can facilitate the school and home in reinforcing each other.

Even as the number of children enrolled in schools is gradually increasing, there is still a vast majority that attends irregularly, drops out or never enrolls. While school children at least get some exposure to health education, the latter group of children are more difficult to reach. In addressing this group, it is important to:

* identify who they are, where they are and what are their sources of receiving information
* consider their varied circumstances and needs
* remember that unlike school children, these children are not

familiar with organised learning approaches - hence the need to use/devise approaches that are innovative, flexible and captivating that enable them to relate the content to their day to day lives. The non formal centres and the voluntary sector need to play a more active role in this direction.

An approach that has been widely used for health education of both school going and non-school children is the **Child to Child** approach. Through this approach, attempts are made to develop in children the knowledge, attitudes and behaviour necessary to manage their own health needs and the skills to help others to do the same. A basic prerequisite of the approach is that learning should be activity based; that the child should be an active participant in the educational process and not merely a passive recipient as happens in the didactic mode of teaching. The objective is to enable children to learn to link knowledge gained through external sources with their experience gained at home and learn to apply and test that knowledge through practice. In developing countries, where older children, especially girls, play an active role in the rearing and care of their younger siblings, this approach has been found to be specially beneficial for both the younger as well as the older child.

The possible areas of intervention in formal and non formal education sectors can be:

Ensuring adoption of a broader view of health instead of emphasising only diseases and cure, by including teachers, social development and community level health workers.

Enhancing the priority given to health promotion within schools, community and non formal centres.

Adopting alternate methods/approaches alongwith/in place of didactic instruction so that knowledge gained can be applied to daily life.

Increasing training facilities and support for teachers and field workers.

Improving the environment and surroundings of the school and non formal centres.

Establishing links between the health and education department.

Establishing links between school and community.

Developing necessary material for health information and education.

Concentrating on improving the health of the girl child.

CHETNA envisages to intervene through education and training in health and nutrition; orientation and sensitising the teachers and educators to implement the school health programme more effectively, networking and advocacy for empowerment of children so that they can become partners in health and development programmes.

ADOLESCENT HEALTH

14-18 years

Adolescence, the transition between childhood and adulthood, is a stressful period of life characterised by discernible/ perceptible physical, mental, psychological and social changes. Marked morphological changes in almost all organs and systems of the body are responsible for the accelerated growth and the changes in contours and sexual organs. There are noticeable changes in the patterns of thinking, attitudes, ideals, relationships, moral standards and abilities in evaluating options for adult life and making decisions. Accompanying mental and psychological changes result in feelings of insecurity and conflicts. Socially, adolescence consists in shifts from dependency to autonomy, social responses to physical maturity, the management of sexuality, the acquisition of skills and changes in peer groupings.

Adolescence is thus a challenging and critical time of life. On the one hand, the excitement of important life decisions and new experiences enraptures, and on the other, growth spurts and emotional changes often torment adolescents, plunging them into a sea of turmoil. In addition, a strong need to establish an identity and self image demands changes in the patterns of emotional dependency developed through childhood.

Adolescence also provides a unique opportunity to compensate for growth retardation that may have occurred during the early years of development. Optimum care and guidance provided during this period can help the adolescent develop to their optimum potential. It is extremely critical therefore to address the developmental needs of this group, particularly of girls who face the greatest degree of discrimination during this phase from their family as well as society. In terms of education, food intake, access to health care and growth patterns, adolescent girls are usually found lagging far behind their male counterparts.

The body of an adolescent girl is critically in need of appropriate nutrition in view of the accelerated growth spurts and onset of menstruation. However, due to gender discrimination, she is unable to receive appropriate nutrition. This often results in anaemia and other deficiencies that affect her entire well being. Social discrimination affects not only the physical health of adolescent girls but also their sense of self worth and confidence.

In a vast majority of families, economic pressures coupled with the dismal scenario of the educational system lead to the exclusion of girls from education. Instead they are expected to conform to social/cultural role expectations and rarely enjoy the opportunity to develop an individual identity. While young girls are taught to be housewives and mothers, young boys are learning to be caretakers and breadwinners of the family. The latter's contribution is measurable in economic terms, leading them to earn greater respect and develop an attitude of superiority over their female counterparts. Predeciding and firmly establishing such specific roles of the adolescent in the home and outside it puts tremendous pressure on them.

Despite child labour being illegal for children below 14 years, it is a common feature. Most of the employed adolescents are engaged in labour intensive, less remunerative occupations in the unorganised sector. This has significant implications on their health, especially females, as it is aggravated by their nutritional and general health status. While illiterate adolescents may be employed in occupations ranging from work in glass factories to domestic labour, the semi-

literate and literate adolescents face greater pressures since job opportunities for them are extremely limited. Lack of challenging experiences leave the adolescents frustrated and unhappy. During this stage, there are contrasting pressures on the rural and urban adolescents which widens the already existing gap between them. The pressure of academic achievements and excellence increases on urban adolescents. Competition is at its peak and this threatens their self image.

Above all, in India, traditionally, the transition from childhood to adolescence, particularly among females has tended to be sudden. Although due to poor nutritional status, the biological onset of adolescence among females may be later in India than elsewhere, marriage and onset of fertility occur far earlier, thrusting adolescent females early into adulthood. Sexual activity also increases during this period, comparatively higher in the case of boys than girls. In the absence of reliable sources of information, adolescents often turn to and rely on unauthentic sources which include peers and friends who are equally uninformed. This is further complicated by the media and satellite television airing uninhibited lifestyles, as a result of which adolescents are often faced with a conflicting set of values and restrictions imposed by their family and society. A young woman's ignorance of sex and safe measures coupled with a lack of decision making in sexual relationships can be easily exploited, resulting in unplanned and unwanted pregnancies. The alarming rise of HIV/AIDS, prostitution and sexually transmitted diseases is a direct result of the lack of sex education and this can have life threatening effects.

Field realities indicate that adolescents are not accorded due importance, either in health or in education and development programmes. Unfortunately their needs have not been understood by parents, society, policy makers or health professionals. Few effective programmes strategically respond to the specific needs of the adolescents who will soon be adults. Parents and individuals working with adolescents often approach them with preconceived notions about this phase of life and view them as problems instead of realising their immense potential as recipients and implementors of health messages.

While the needs of children or pregnant women are acknowledged in national strategies and programmes, neither services nor research have focused on adolescents and their unique health and information needs. Although the adolescent may not appear as frequently as children and adults, especially women, in morbidity and mortality statistics, the long term repercussions of their behaviour may lead to a variety of health problems that can be avoided/forestalled with planned health interventions for them.

The present policies and programmes for adolescents have a number of shortcomings. They tend to directly or indirectly re-emphasise gender biases and in some ways also undermine the capacities of adolescents to participate in their own development. The special characteristics and needs of adolescents require focused policies and programmes.

Individuals and organisations must respond to the needs of the adolescents in the perspective of the social characteristics of this group, keeping the gender dimension in view. The range of intervention areas include health and nutrition, education, sex education, parent/teacher/community awareness, economic and other relevant activities like support and guidance, skill oriented training for adolescents etc. Importance should be given to life useful education. Special efforts need to be made towards raising their self-esteem, level of confidence, analytical problem solving abilities, communication, leadership and vocational skills which can help them become self reliant and independent. Last but not the least, participation of adolescents must not be ignored as their immense energy and potential needs to be channelised on the path to development.

CHETNA envisages sensitisation and capacity building of field based practitioners, programme managers, trainers and policy makers and build their perspective about adolescent health and developmental needs and building skills for effective programme management.

Existing IEC material concerning adolescents will be reviewed, new need based material developed and disseminated particularly on sexuality and reproductive health.

CRC'S STRATEGY
AGE-SPECIFIC CONCERNS OF CRC

Early Childhood

0-3 years

* High Infant Mortality and Morbidity rate
* Lack of information among parents
* Lack of stimulation
* Non availability and under utilisation of health facilities/ services
* Poor nutritional and health status
* Discrimination of girl children

3-6 years

* Lack of child centred preschool education
* Lack of information among parents leading to their own -involvement in programmes
* Poor nutritional and health status
* Poor utilisation of existing services
* Discrimination of girl children

School Age

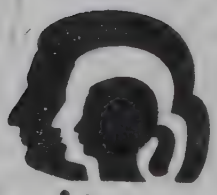
6-14 years

* Lack of nutritional, health and education facilities
* High rate of school dropouts particularly girls
* Didactic teaching approach
* Low motivation level of teachers/facilitators/management
* Inappropriate/inadequate weightage to nutrition and health aspects in the existing curriculum
* Lack of child centred policies and programmes both in formal and non-formal system.

Adolescence

14-18 years

* Lack of services and awareness regarding needs of adolescence
* Lack of self esteem and self confidence
* Unhealthy attitude of parents and society
* Lack of knowledge on sex/sex education
* Lack of accessible health services
* Other issues concerning their health
* Lack of empowerment opportunities and irrelevant education
* Gender discrimination



Chaitanyaa

TOWARDS A COMPREHENSIVE WOMEN'S HEALTH PROGRAMME

Health care, gender and patriarchy in India

The Health Care System:

India has one of the most extensive infra-structures for health care in the developing world and a optimum doctor/population ratio as recommended by the World Health Organisation (WHO). In spite of this reality, the hospital based diseases are on the rise and care oriented approach towards the establishment of medical services are not functioning optimally. There are various reasons responsible for this which have made the situation complex.

An overview of the health care system in India indicates that although the majority of India's population is concentrated in the rural areas, the health system in India is biased towards providing health services in urban areas. Doctors are not attracted by Government policies to practice in rural areas as they do not see a future there. In general, the medical system is male dominated and even female doctors conform to a male oriented system. Another unfortunate reality is that, according to many studies, government health care facilities provide medical care below the expected standard and are not meeting the perceived health needs of the people especially that of poor and under privileged sections of the community.

Many available studies indicate that both in rural and urban areas, the proportion of women attending the out patient clinics and being admitted to hospitals or primary health centres is always less than that of men. This indicates neglect of health care needs for women.

In spite of rapid increase in health care infrastructure under the

auspices of the health care services provided by the government, the improvement in the quality of services is marginal. The private health care sector has expanded considerably in the last few years. A number of studies have reported that people generally prefer private health care facilities even though it is more expensive. However, this cannot be equated with better quality care and efficiency. In a national survey, it has been observed that sometimes medical expenses are so high that they are a major cause for rural indebtedness next only to dowry.

During the recent years, a continuous decline in government allocation of funds to the health sector has been observed. Due to the structural adjustments, the expenditure on medical services have fallen marginally, however, the fall in expenditure for disease control is very sharp. The disease control programme deals with infectious diseases that mainly affect the poor communities.

In such a situation it is very important to recognise the role of Indian traditional healing practices to improve the overall health status of disadvantaged communities. There is an urgent need to revive the traditional healing practices and to increase the knowledge of people for home based herbal medicine, non drug therapy and promotion of a healthy life style.

The Evolution of Health Care

Before the industrial revolution and the consequent emergence of the market economy, families and communities produced their own food, clothing and tools. Under the same roof, babies were born, children were raised, sexual relations took place, people fell sick, grew old and died. Biological and productive lives were combined within the same household. While there were marketplaces where surplus produce was bartered, there was no formal market economy.

Authority in the family was vested in the elder males of the family. This patriarchal rule of the household was reflected in the governance of villages, religious institutions and the nation.

One significant feature in this traditional system, however was its gynocentric nature. The woman's role was central to the production process within the household. Healing skills were the responsibility

of woman; her knowledge of herbs and common ailments of the family gave her an identity and value within the social structure. If she was exceptionally skilled, the community would consult her for care, as a herbal healer or midwife (Traditional Birth Attendant). It was not considered as a profession but was a humanitarian act. In due course of time, several health care systems developed in the ancient cultures of India, China, Greece, Egypt etc. They took the shape of a regular system of medicine like Ayurveda, Acupuncture, Yunani and Siddha. Though they were limited to the upper class and castes, they were near to nature and human body. Unfortunately, this male dominated system kept women out of its purview.

With the emergence of the market economy there was a total social transformation. In the old order, production was governed by natural factors - the human need for food and shelter, and the limits of labour and resources.

In the nineteenth century, with the rapid development of industrialisation and the Industrial Revolution in Europe and America, production of consumer goods shifted from the household to the factory. The household became the place where only personal biological activities took place: eating, sleeping, sexual relations, child-bearing and rearing and care of the infirm and aged. There was a clear division between the public sphere, which was governed by the market, and the private sphere, where the household became a place for comfort and care.

At the same time, yet another change was taking place which has its roots in the 17th century, during the Renaissance period in Europe. For the first time, religious doctrine and traditional authority were being challenged. Scientific research was spurred on by the growing market economy. Old beliefs floundered against scientific research and theory. All over the world, science was progressing in leaps and bounds. Scientists claimed the entire observable world as an area for unfettered experimentation, free from religious and feudal interference. What was once divine and mysterious began to be explained scientifically.

Rapid industralisation resulted in a large number of women working outside the home. For sometime women managed to retain their

traditional knowledge of healing. Gradually however, modern science took over the entire field of medicine. Although laboratory science had not yet developed, the scientists pushed out the women healers who had learnt from observation and long experience how to deal with basic health problems. Modern science became the ultimate authority in the conflict that arose between the traditional wisdom of women healers and new male expertise.

Though scientific research did lead to Pasteur's discovery of bacteria, a unicellular organism, as the cause of diseases, dispelling the belief that illness was a punishment for one's sins, it also lead to the gradual removal of women healers and the traditional systems of medicine. The scientific theories were liberating in the sense that they removed people from the clutches of religion. But the negative outcome of this progress was that the allopathic system had started viewing diseases and the body separately leading to compartmentalising of the healing process. The approach of holistic health was kept aside. The women lay-healers operated within a network of information sharing and mutual support. The medical profession mostly shared its knowledge within an elite group which resulted in the destruction of women's networks. Many women were marginalised in the process and later became dependent on the Allopathic mode of treatment.

Regardless of their class, women were entrusted with only one responsibility: reproduction. Health care, however, was not accessible to all. Only wealthy women could afford expensive and prolonged medical treatment (in the interest of the medical practitioners) while working class women were unable to pay for professional medical help.

Medical experts began to develop an evolutionary theory of women. Out of their ignorance and prejudice, the theorists regarded women merely as reproductive units. Some of these theories described the uterus as a controlling organ of a woman's body. In fact, it was believed that God, in creating woman, had taken a uterus and built her around it. Women were viewed as less-evolved creatures than men, and from this evolved the theory of contemporary human sexual differences. Men were made to fulfill a variety of functions in

the social division of labour, while women were designed to reproduce.

Presently, the field of medicine is mainly male dominated and though there are a large number of female doctors, the professional attitudes they adopt are essentially male attitudes. Women, who are seen as a problem are reluctant to articulate their health complaints. For example, many women would like to know more about birth control methods which are suitable for their lifestyle. But, birth control information, as a means to helping a woman to lead a sexually satisfying life without the fear of a pregnancy, is viewed with suspicion (because it could lead to a sexually liberating lifestyle). Birth control is viewed merely as a part of a family planning programme used by the state as a means of population control. New economic policies and theories like SAP (Structural Adjustment Programme) promoted by the International Monetary Fund (IMF) and the World Bank push the governments of Southern countries to make heavy cuts in their health and development programme budgets, which directly affects the poor and particularly women.

Patriarchy and Gender

Patriarchy denotes a structured system of male domination. These are not merely differences between men and women, but contradictions and structures of exploitation and oppression. The literal meaning of **patriarchy** is rule of the father. It is often used to describe a male-dominated family and the power of the father and husband over the family and its assets and resources.

Patriarchy exerts its power over biological reproduction and sexuality; men try to gain control over women because of their reproductive capacities and sexuality. The marriage contract enables men to control women's sexuality and fertility in return for women's economic survival. Patriarchy can be described as a set of social relations among men which have a material base and which establish or create interests to dominate women. The material base upon which patriarchy rests lies most fundamentally in men's control over women's labour power.

Women are identified with the reproduction of life, of subsistence, whereas men are identified with other forms of production. This basic form of women's labour and its exploitation is the base for all the varying forms of their oppression, whether sexual, political, ideological or religious, and this oppression can be linked to women's poor health.

The term **'gender'** is being used to indicate a social frame work as distinct from **'sex'** which is a biological form. Gender roles imply assigning each sex certain characteristics and expectations.

Gender-assigned characteristics for men include:

Right to quality food, clothing, education, self- reliance, self-confidence, independence, health, aggressiveness, fearlessness and potency.

Gender-assigned characteristics for women include:

Beauty,tolerance, passivity, dependence, submissiveness, obedience, self-sacrifice, affection, and nurturing.

When discussing health, the Sexual Division of Labour (SDL) is crucial. Due to gender roles, the burden of labour falls on women's shoulders. Despite the energy expended in performing the multitude of gender-assigned tasks, women do not receive commensurate nutrition within the household - they eat last, least and leftovers. As a result, women suffer from serious health problems.

The sexual division of labour implies that the allocation of tasks assigned to men and women differ according to their gender. Less value is placed on tasks performed by women, both materially and ideologically. The ideological evaluation of women's work is the most crucial and puzzling aspect of the sexual division of labour. Women are remunerated less than men for the same tasks performed.

With this broad understanding, Women's Health and Development Resource Centre is addressing various health concerns of women.

NUTRITIONAL STATUS OF WOMEN

Malnutrition plagues the majority of disadvantaged women in India. Existing gender biases in the society introduce the cycle of malnutrition among women from early childhood onwards. Due to the low value placed on the girl child, from birth itself she receives less food and that too of inferior quality than their infant brothers. This discriminatory approach continues throughout childhood, adolescence and in adulthood. Older girls and adult women work more and spend more energy in comparison to their food intake. Malnutrition among women is further exacerbated by frequent pregnancies and lactation. This depletes her limited nutritional reserves. Indian women, on an average, become pregnant eight times and give birth to six to seven children.

A direct result of undernutrition is anaemia, a condition that plagues over 70% of India's women (W.H.O). Anaemic women have low resistance, causing infection, weakness, low energy, dizziness and loss of appetite. A WHO report states that Anaemia contributes to high maternal mortality and morbidity. Upto 20% of maternal deaths are directly due to anaemia.

National programmes have not been effective in combating anaemia for various reasons. Generally, women are not aware of the National Anaemia Prophylaxis Programme. As a result of this, pregnant women and nursing mothers are not made aware about the need for an iron and protein rich diet. The national programme usually address this concern during pregnancy which is often too late as the deficiency begins in early childhood. Short term iron supplements during pregnancy do not compensate for the years of anaemic condition in girls and women.

Existing nutrition programmes do not address women's nutritional needs from infancy to old age. Even programmes that teach women how to prepare balanced and nutritional meals do not recognise that women rarely have decision making/purchasing power to enable a good diet for herself. It fails to recognise that women are malnourished due to their secondary status within the family, where they usually eat last and leftovers.

CHETNA believes that high incidence of malnutrition and anaemia among disadvantaged Indian women is not entirely due to poverty. There are cultural, social and educational barriers that prevent women from ensuring adequate nutrition. To address this problem, CHETNA will make efforts to raise the awareness and social status of women. This will be done through trainings and developing need based health education material which will be widely disseminated among health practitioners and community.

MATERNAL HEALTH

Despite the traditional focus on maternal health programmes, national statistics indicate that India has one of the highest rates of maternal mortality in the world.

The maternal mortality rate in India is as high as 400 to 500 per 1,00,000 live births. The numbers continue to reveal the grim state of maternal health in India.

* Statistics indicate there are more maternal deaths in India in one week than there are in all of Europe in one year;
* In one day in India, the total number of casualties due to pregnancy and childbirth related complications are more than those recorded during one month in the entire developed world;
* In India, the probability of a woman's death during pregnancy is one in 18.

There are several reasons for this grim situation. Post-partum haemorrhage, often caused by anaemia, and sepsis are the most frequent causes of maternal death. Women lack adequate prenatal, natal and post natal care. They harbour several misconceptions about a proper diet during pregnancy. These problems, coupled with frequent pregnancies, contribute to high maternal mortality rates. With each pregnancy, women increase the risk of being exposed to infections and birth-related complications. Despite the

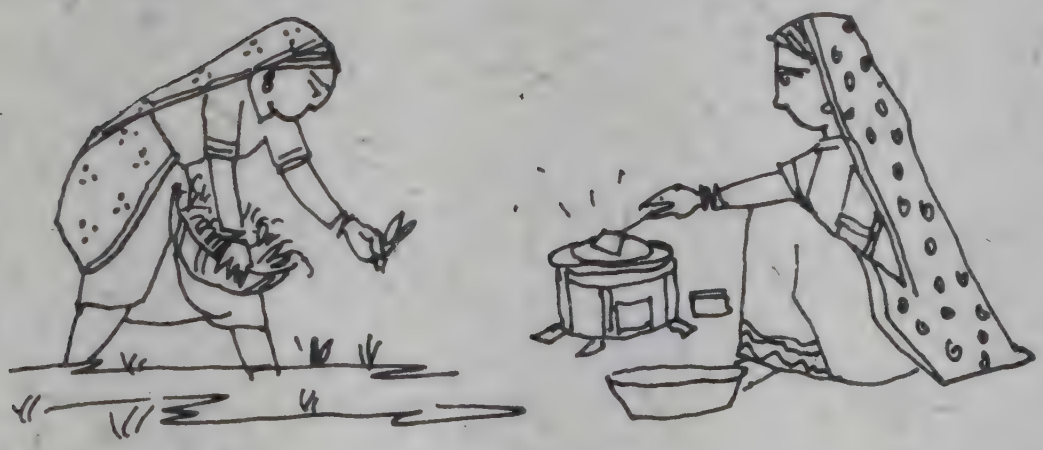
gravity of the situation, there is a lack of trained health care workers at the field level. At the same time, the proven healing capacities and knowledge of the traditional birth attendants (dais) are often undervalued. The mainstream health care system does little in terms of upgrading her skills and providing her the much needed support. The result is marginalisation of this cadre of healers who provide emergency and promotive health care to women in interior and far flung areas at their door step.

For women who decide to have an abortion, the risks are greater. According to one study, abortions account for 10.7 percent of pregnancy-related deaths. Despite the legality of abortion, in India millions of women risk their lives in the hands of local abortionists due to social and cultural reasons.

CHETNA believes that the majority of these problems are rooted in the existing social and economic situation: inadequate health services, lack of control over fertility, overwork, inadequate nutrition, poverty, lack of education, clean water, proper housing, discriminatory attitudes, beliefs, taboos and practices in the family and society. There is a need to address all the above issues related to maternal health rather than concentrating on any one.

CHETNA envisages to address these concerns in its capacity building trainings and health awareness programmes. CHETNA visualises a critical role of Traditional Birth Attendants (TBAs) in lowering the maternal mortality and morbidity rate. It will concentrate its efforts in strengthening the capacity of TBAs and advocating the same at the policy level.

WOMEN'S WORK AND HEALTH



In a patriarchal society, the definition of work conveys two different meanings for men and women. While men's work is limited to only income generation, for women, apart from income generation, they have to do household work, prepare food, collect firewood and fetch water, take care of children and nurture family and community needs. Lack of mobility, education, skills and gender based discrimination restrict women from securing higher paying jobs.Therefore, while men's work is considered to be productive, women's work is greatly undervalued in economic terms. Time allocated to household activities other than agriculture is rarely recognised and rewarded.

Non recognition and under valuation of women's work both at home and outside, has an adverse effect on women's health. Lack of time available for the tasks that need to be done frequently increases the intensity of work. Hours for leisure time activities or even sleep are reduced. Arduous and strenuous physical tasks done by women, combined with limited food intake further exacerbates malnutrition among Indian women. It is ironic to note that about 70% of Indian women suffer from anaemia and hence are more prone to infections. Communicable diseases are on the rise among poor women in India.

80% of the women work in the unorganised sector where the

working conditions are such that it affects their physical and emotional health. The occupational hazards are high, but they have no claim for compensation. This affects their productivity, work output and wage earning capacity. Due to these socio-economic interlocks a vicious cycle of poverty, poor health and lower wages is set in motion.

CHETNA recognises that to improve this situation, women's work, both at household and work place needs to be recognised and rewarded within the existing social, economic and political context. It is essential to identify and address the factors affecting women's health due to over work, in a holistic manner. CHETNA envisages to sensitise the NGOs and GOs working in the area of occupational health of women to expand their understanding to recognise women's household work and its effect on her health.

REPRODUCTIVE HEALTH

In India's health care system, reproductive health concerns of women were largely neglected until the International Conference on Population and Development (ICPD) brought the concern to the forefront in 1994. In the post ICPD era, the country is in a stage to formulate its Reproductive and Child Health policy. There is a fear that due to a narrow focused approach it is possible that at the implementation level the global thinking of reproductive health may get translated into family welfare activities.

Due to socio-cultural factors which prevent the dissemination of information and discussion of women's reproductive health, the suffering of women is neither detected nor treated in time. Often, by the time a woman seeks medical attention, it is too late as damage has already taken place. At the grassroots level, untrained para-medical workers are not able to treat or guide her appropriately. Reproductive Health Care is an extraordinary challenge. The Government of India has responded positively to this challenge changing existing policies of the Family Welfare Programme to a Target Free Approach and accepting the implementation of a reproductive health programme which is centred around the highest possible quality care, client based approach and community participation.

Today the country has a unique opportunity to understand the complexity of the problem and address it through its reproductive and child health programme. The programme needs to address the

reproductive health needs of women through a holistic perspective throughout the lifespan and by involving males. The programmatic intervention on reproductive health, needs to be balanced and integrated with the other health needs of adolescents, adult women and older women.

Several women's groups and NGOs need to come forward and share their rich experiences in the area of reproductive health to strengthen the programme. CHETNA has experienced that women are willing to discuss their reproductive health problems in a supportive and enabling environment.

CHETNA envisages to address the issue of reproductive health through a life cycle approach and by integrating it in women's holistic health perspective. It will address components like reproductive tract infections, abortion, sexually transmitted diseases (STDs), Acquired Immuno Deficiency Syndrome (AIDS) and HIV, contraception etc. CHETNA also envisages to collect community based data on socio-cultural aspects on emerging issues like sexuality of women and adolescents and health concerns of women like breast and cervical cancer.

EMOTIONAL HEALTH

Indian women suffer from blatant and overt discrimination every day at work, at home, in the endless tasks they must perform. Domestic and occupational responsibilities leave little time for leisure activities and self-awareness. Women find they have little control over their lives. Lack of education limits their ability to question their secondary role in a society and the inequalities that they face every day. Lack of an enabling environment where they can discuss their problems is another constraint. Such a repressive situation can soon manifest itself into mental illness.

Single women are harassed by curious neighbours and pressurised by parents and society to conform to the existing conventions . When married, a woman must leave her family and home and assume the role of a dutiful wife and daughter-in-law and submit to the control of her husband and his family. Violence, sexual assault and excessive dowry demands are socially sanctioned within the privacy of the family/home. Women are expected to suffer all these assaults in silence. The strain and isolation of such an unfriendly environment can easily result in mental breakdown. Many women's group believe that the anguish women suffer must be viewed as a product of a discriminatory society. "Until the girl is taught to value her self and her contribution to society and unless society acknowledges that contribution, the cycle of neglect, indifference and conscious discrimination will continue unabated with all its adverse consequences". (State of India's Health, 1992).

CHETNA in its ongoing programmes will focus on the emotional health of women. It will sensitise and motivate NGOs to take up the issue of emotional health in their Women and Health programmes. Sensitisation material will also be developed to reach larger audiences.

VIOLENCE AND WOMEN'S HEALTH

Violence against women has been endemic in our society from ancient times. Although all people are affected by violence, women are the most vulnerable to it and have experienced it largely because they are women. It is sad that in our patriarchal society, women often accept the male right to violence and usually keep silent about their suffering. The social pressure regarding violence is extremely strong that it prevents other women from resisting it or extending support. Usually the women who experience violence is convinced herself about the myth of "male right to violence" as a truth of life. An expression shared by many women highlights the seriousness of the problem in our society.

"Since last few months, my husband has stopped loving me, he does not even beat me."

A revealing text printed on a poster to stop the cycle of violence further brings out the inner feeling of many people who have experienced violence or working to stop violence.

"He would not hurt a flea but he puts his wife in a coma".

It is ironical that violence as an issue has been neglected by majority of groups working in the area of women's health. Taking a closer look at the issue, it indicates that violence at the most basic level affects women's physical and emotional health. Today when many of us are addressing women's health in the frame work of rights and empowerment, we need to recognise that violence is an issue of power relationship between men and women; it takes away the control of the body.

Violence is linked with various issue of women's health, like mental and emotional health, infertility, pregnancy, sexual health, pregnancy, etc. CHETNA, plans to address the issue of **violence and women's health** through sensitising of health groups to understand the link between violence and women's health. CHETNA will network with local NGOs working in the area of violence and link them with health groups. Such networks will endeavour to bring the violence and health groups together to take up joint action at the field level. CHETNA in its ongoing trainings also envisages to link violence and health so as to make this perspective reach out to wider audiences.

Empowering Women Through Promotion of Beneficial Traditional Health Practices

Traditional Health Practices

For centuries, family and community health care was the sole responsibility in the domain of women. Knowledge of traditional healing methods was passed from one generation to the next and women who were especially skilled or knowlegable held a valuable position within their families and communities. Due to their experience and observation of traditional healing, women were able to control their own health care needs and those of their families. Gradually the process of changing women's healing knowledge was condemned by practitioners of modern medicine which led to lowered credibility of traditional healers.

For Indian women who live in isolated areas and villages, a visit to the regional health care centre means loosing a day's wages. Arrangements have to be made for child care, and savings must be sacrificed for transportation to and from the health centre. Transport facilities are generally poor and do not operate frequently. Upon arriving at a health facility, many women are intimidated by the insensitive staff as there are few female doctors available to treat them. Illness and its treatment are a mystery for the poor and

disadvantaged women, usually because doctors find little time to explain the causes of the ailments and counsel on medication and possible side effects.

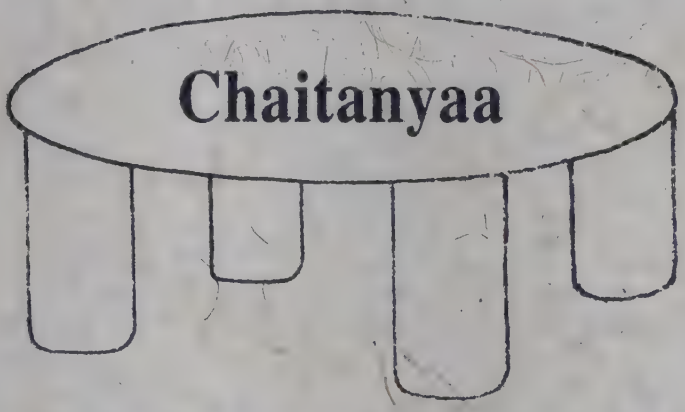
Most of the times, prescribed medicines are not available in primary health centres free of charge. When medicines are available, it is often too expensive for most women.

By studying local health traditions - those which are easily available, accessible and affordable - and sensitising local health care workers to traditional healing practices, women can regain some of the empowering aspects of traditional health. Birth attendants can upgrade their traditional skills to include appropriate hygiene and sterilisation techniques. Some medical knowledge and treatments can be given to women in the community through health education, counselling and training.

At the same time, existing traditional health care and healing practices must be assessed to determine their efficacy. Many treatments, passed on through generations may be effective which could preclude the use of drugs and tablets. Some herbal treatments are locally available and affordable as well as being simple to prepare. Their use could enable women to exercise some control over their health care needs.

CHETNA believes that a woman's health programme must recognise the empowering effect of a woman's control over her own, her family's health and the community's health. Traditional healing practices provides a model to be studied, and in some cases, adopted. CHETNA will promote traditional health practices in its ongoing programmes. It will also motivate other NGOs and GOs to recognise positive traditional health care and healing practices in their programmes. CHETNA will make efforts to advocate on traditional health practices at the state, national and international policy level.

THE FOUR PILLARS OF CHAITANYAA



The following four pillars represent the underlying principles of WHDRC's philosophy and strategy.

INTEGRATIVE

WHDRC recongises that a woman's health encompasses her social, physical, and emotional well being. These are considered to be interconnected and will be addressed together in an integrative fashion.

HOLISTIC

WHDRC does not see women merely in their roles as mothers. The programme will focus on all the stages of the life cycle: infancy, childhood, adolescence, adulthood and old age. WHDRC believes that only by addressing the distinctive concerns of each stage can there be significant improvement in women's overall well being.

GENDER SENSITIVE

WHDRC recognises that gender discrimination is one of the important determinants of women's low health status. Thus, understanding and addressing the implications of gender relations, and enlisting the participation of men and the community would be central to its efforts in enhancing women's health and development.

REALISTIC

In its anlaysis and approach, WHDRC considers the totality of political, economic and social factors that shape women's environment, particularly norms, traditions, taboos, religion and other forces which affect women's ability to control and improve their health status.

WHDRC'S STRATEGIC HEALTH CONCERNS

WHDRC will continue to focus its attention on Nutrition, Maternal and Child Health and Communicable and Infectious Diseases. Anaemia which is prevalent among women of all ages, will receive special attention. In its new strategy however, WHDRC envisages to address Reproductive and Emotional Health as part of its effort to enhance women's overall health status.

NUTRITION

ANAEMIA AND OTHER DEFICIENCY DISEASES, MALNUTRITION, LOW-COST FOOD AND AWARENESS OF A BALANCED DIET AND FOOD GROUPS.

MATERNAL & CHILD HEALTH

PRENATAL, PERINATAL AND POSTNATAL CARE, BREAST FEEDING, MISCARRIAGE, ABORTION, FEMALE INFANTICIDE PRENATAL SEX SELECTION

INFECTIOUS DISEASES

SKIN DISEASES, WATER, AIR BORNE AND RELATED DISEASES, PREVENTABLE AND COMMUNICABLE DISEASES, HYGIENE AND SANITATION

REPRODUCTIVE HEALTH

MENSTRUATION
SEX EDUCATION,
INFERTILITY
CONTRACEPTION
MENOPAUSE
PELVIC INFLAMMATORY DISEASES, REPRODUCTIVE TRACT INFECTIONS, STDS AND HIV,

WOMEN'S WORK AND HEALTH

MULTIPLE BURDEN OF WORK, AND RELATED HEALTH HAZARDS, HARASSMENT
CULTURAL AND SOCIAL STIGMAS
ABORTION, AIDS
CANCER

EMOTIONAL HEALTH

LOW ESTEEM,
LOW SELF-CONFIDENCE,
MENTAL DEPRESSION,
SAFETY GEAR, SEXUAL
LACK OF DECISION
MAKING POWERS AND
BREAST AND CERVICAL

CHETNA'S LIFE CYCLE INTERVENTIONS

Through CHETNA's holistic approach, all stages of women's life cycle will be addressed.

INFANT (0-1)	CHILD (2-9)	PRE-ADOLESCENT (10-12)
NEONATAL, PRENATAL AND POSTNATAL CARE, BREAST FEEDING, BUILDING WEANING, IMMUNISATION, PREVENTION OF DISEASES, PROMOTION OF SOUND, TRADITIONAL HEALTH PRACTICES, AND SENSITISING AGAINST GENDER DISCRIMINATION.	NUTRITION, PREVENTION OF DISEASES, IMMUNISATION, SENSITISING AGAINST GENDER DISCRIMINATION, AND RAISING SELF-ESTEEM.	NUTRITION, SEX EDUCATION, PREVENTION OF DISEASES, BUILDING SELF-ESTEEM, AND PROMOTING HEALTHY SOCIAL BEHAVIOUR.

ADOLESCENT (13-19)	ADULT WOMAN (20-45)	OLDER WOMAN (46+)
NUTRITION PREVENTION OF DISEASES, SEX EDUCATION, REPRODUCTIVE HEALTH, PREPARATION FOR MOTHERHOOD, WOMENS WORK AND HEALTH SENSITISING AGAINST GENDER DISCRIMINATION, AND RAISING SELF-ESTEEM, SEXUALITY.	NUTRITION, PREVENTION OF DISEASES, IMMUNISATION, MATERNAL AND REPRODUCTIVE HEALTH, SEX EDUCATION, WOMENS WORK AND HEALTH PROMOTION OF SOUND TRADITIONAL HEALTH PRACTICES, SENSITISING	NUTRITION, PREVENTION OF DISEASES, GYNAECOLOGICAL HEALTH (MENOPAUSE), WOMENS WORK AND HEALTH PROMOTION OF SOUND TRADITIONAL HEALTH PRACTICES, AND RAISING SELF-ESTEEM. AGAINST GENDER DISCRIMINATION, AND RAISING SELF-ESTEEM.

CHETNA

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